

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 2/13/04.

## **I. DISPUTE**

Whether there should be additional reimbursement for date of service 2/18/03. The Carrier denied additional reimbursement for CPT code 20550 as "U RG – The treatment/service provided exceeds medically accepted utilization review criteria and/or reimbursement guidelines established for severity of injury, intensity of service and a ppropriateness [sic] of care." CPT code 64443 was denied as F – YF – Reduced or denied in accordance with the appropriate fee guideline ground rule and/or maximum allowable reimbursement (MAR). G YG – Reimbursement for this procedure is included in the basic allowance for another procedure."

## **II. FINDINGS**

On 4/01/04, the Requestor submitted a withdrawal letter for date of service 2/18/03, CPT code 20550 denied as unnecessary medical. On 4/02/04, a Notice was faxed to the Requestor to submit additional documentation necessary to support the fee charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the requestor's receipt of this Notice.

## **III. RATIONALE**

### **Date of Service 2/18/03; CPT Code 64443; (Lumbar Facet Injection)**

The Requestor billed CPT code 64443 for five (5) additional levels, which is a starred procedure. According to the Table of Disputed Services the Requestor billed \$1,430.00. The MAR amount is \$111.00 for each additional level. The Carrier reimbursed \$222.00 leaving \$333.00 in dispute. Based on the 1996 MFG SGR (II), the global fee concept for surgical services cannot be applied. Therefore, additional reimbursement is recommended in the amount of \$333.00(\$555.00 MAR - \$222.00 Carrier reimbursement = \$333.00).

## **IV. DECISION & ORDER**

Based upon the review of the disputed healthcare services within this request, the Division has determined that the Requestor **is** entitled to reimbursement for CPT code 64443 in the amount of **\$333.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **\$333.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 02nd day of June 2004.

Pat DeVries  
Medical Dispute Resolution Officer  
Medical Review Division

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